risks before beginning or continuing such lifestyle abuse?

I am forced by these concerns to hesitate before wholeheartedly accepting Kluge's argument.

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We are obliged to respond to the article by Dr. Kluge because it contains factual errors about the policies of our liver transplant program at the University Hospital, London, Ont.

Kluge argues that patients who become ill as a result of lifestyle abuse do not deserve the same rights of access to care as patients who have led healthy lifestyles. He uses the example of an alcoholic who needs a liver transplant. He refers to our guidelines for allocating donor livers and cites an obscure publication (Canadian Health Care Management Dispatch DP 53.2 [1990]), from which he declares that "drinkers have been placed at the bottom of the list." That is incorrect.

Our policy with respect to liver transplantation is simply and concisely stated. To be considered for transplantation patients must "demonstrate that they are capable of complying with medical advice and routines." In the case of patients with a history of alcohol abuse, this compliance condition requires confirmed abstinence from alcohol outside of hospital for 6 months or more and a psychosocial profile that convinces us that a return to drinking is unlikely. Alcoholic patients who satisfy these criteria are placed on the transplant list, and their priority ranking is determined by the same criteria as those applied to all the patients on the list — namely, how sick they are, whether their blood group is compatible with that of the donor and how long they have been waiting. The cause of the liver disease is not a factor.

This policy was approved by the hospital ethics committee and the board and has proven useful in balancing the responsibilities of the program to the patients and to society. Kluge's misunderstanding seems to be rooted in a series of media reports containing less and less accurate interpretation by people progressively farther from the source of the policy. In the publication Kluge cites, a hospital spokesperson expanded on the policy but did not suggest that it prioritized candidates for transplantation according to lifestyle. Nevertheless, the publication stated that the policy "puts many alcoholics at the bottom of the list." Kluge further misinterprets the policy to suggest that past alcohol abuse automatically puts people at the bottom of the list. In reality, noncompliance prevents people from being placed on the list, and compliant people are treated equally without regard to their past lifestyle choices.

As well, Kluge incorrectly states that lifestyle considerations are rarely discussed in making decisions about organ transplantation. Our weekly Liver Transplant Conferences are multidisciplinary, and it is unusual to accept or reject a patient for transplantation without lifestyle entering into the discussions.

The issues Kluge raises are complex, and everyone is entitled to an opinion. In Kluge's words, however, "the right to free speech is conditioned by the presumption that this speech will be truthful." The above misunderstandings could have been avoided with some source checking rather than reliance on third- and fourth-hand reports. In areas such as this, small changes in wording profoundly affect the meaning.

Cameron N. Ghent, MD, FRCPC David R. Grant, MD, FRCSC William J. Wall, MD, FRCSC University Hospital London, Ont. I found it an interesting thought in Kluge's article that irresponsible people should not be treated the same as responsible people.

However, I think that Kluge only touches the tip of the iceberg with his examples of smoking and drinking. I suggest that there are many more forms of lifestyle abuse. Sports injuries, for example, are self-inflicted, and participation in sports is not a necessity of life. Another example is travel, a dangerous pastime that one could live without. And let us not forget sex — certainly a risky form of lifestyle abuse.

Should we penalize the nondrinker in whom coronary artery disease develops and the nonsmoker with Alzheimer's disease, which seems to be less common in smokers?

I understand now that to be ethical means to be judgemental rather than compassionate, and this saddens me.

Arnold J. Verster, MD Beamsville, Ont.

Dr. Kluge's article has far-reaching implications beyond the rarefied atmosphere of transplantation.

Opinions relating to societal disbursement of resources apparently now fall into the realm of "ethics." The allocation of medical resources is considered separately from all other economic allocations (e.g., expenditures for senators, royal commissions and professional athletes).

Why disguise opinions as pseudoscience? As an emergency physician at a large hospital I encounter down-and-out patients and social Darwinist attitudes daily. The owners of these attitudes are usually healthy, empowered and apparently superior members of the species.

Whatever happened to compassion, humanity and tolerance?

Michael S. Dettman, MD, FRCPC Vancouver, BC

I grant Dr. Kluge's argument that people who choose to practise unhealthy habits should not expect